# REQUEST FOR TRANSFER TO A DMH ADULT CONTINUING CARE INPATIENT FACILITY**

Patient's Name _____ DOB: _____
(last) (first) (MI )

Referring Facility: _____ Name of Treating Physician: _____
Please print

Address: _____ Telephone: ( ) _____
(number and street) (apt no) (city) (state) (zip code)

**Date of Admission:** _____ **Legal Status:** _____
MM/DD/YY

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**PHYSICIAN'S STATEMENT**

I have reviewed the clinical criteria for referring patients to DMH for continuing care inpatient services and believe this patient requires continuing care treatment. If the patient is accepted for transfer, the transfer will comply with M.G.L. c. 123, § 3.

_____, MD
Signature of Treating Physician

Date: _____

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**INSTRUCTIONS:**

Please send the completed Application for DMH Adult Continuing Care Services, this Transfer Request form, and the following attachments to the Area Medical Director for the Area in which the patient lives (permanent address).

1. Admission history ☐ Attached
2. Physical exam ☐ Attached
3. Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V) ☐ Attached
4. Any other initial assessments (psychosocial, medication, etc.) ☐ Attached
5. Hospital course, including treatment plan, barriers to discharge, somatic therapies and compliance, alternative therapies considered, need for Section 7, 8 and 8b, estimate of response to continued treatment, reason why any recommended treatments were not tried (if applicable) ☐ Attached
6. Last 10 days of progress notes ☐ Attached
7. Current medications ☐ Attached
8. Copies of all medication administration records (MAR) ☐ Attached
9. Copies of any relevant guardianships, including Roger's Order ☐ Attached

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****Note**: This form to be used only in conjunction with an Application for DMH Continuing Care Services. If requesting transfer for a patient who is already a DMH client, please use two-page transfer form (AD-Tform/long/99 in Transfer Protocol).